

PROGRAM BUDGET REQUEST FORM	
To: Department of Public Health, Maternal and Child Health	FOR THE PERIOD OF TOTAL MCH FUND APPROVED
AGENCY NAME	
STREET ADDRESS:	
CITY/STATE:	ZIP CODE:
CONTRACT NUMBER:	
CONTRACT NAME:	
<p>SECTION 1 – NON-MCH REVENUE AND INCOME FOR PROGRAM BUDGET</p> <p>DIRECT FEDERAL REVENUES: \$ _____</p> <p>REVENUE FROM OTHER CITY AGENCIES: \$ _____</p> <p>OTHER REVENUES (IDENTIFY): \$ _____</p> <p>CLIENT FEES (IDENTIFY) \$ _____</p> <p>PRIVATE HEALTH INSURANCE PAYMENTS: \$ _____</p> <p>MEDICAL ASSISTANCE PAYMENTS: \$ _____</p> <p>OTHER THIRD-PARTY PAYMENTS (IDENTIFY): \$ _____</p> <p>OTHER INCOME (IDENTIFY): \$ _____</p> <p>IN-KIND CONTRIBUTIONS: \$ _____</p> <p>TOTAL SECTION 1: \$ _____</p>	<p style="text-align: center;">CERTIFICATION</p> <p>I certify that I am the Facility of said organization, and that the revenues for the period shown on these forms are the best of my knowledge and belief, and are in accordance with the related balances of the Commonwealth, and City; and directives as required by law. I understand that any and all are made in reliance by Mate the statement I</p>
<p>SECTION 2 – REQUEST FOR MCH REVENUE FOR PROGRAM BUDGET</p> <p>TOTAL PROGRAM COST: \$ _____</p> <p>(SECTION 3, PART A, COLUMN 4)</p> <p>LESS: NON-MCH REVENUES AND INCOME: \$ _____</p> <p>(SECTION 1, TOTAL)</p> <p>REQUEST FOR FUNDING TO MCH: \$ _____</p>	Prepared by:
	Facility Director/Administrator (Signature)
	Approved: Director, Maternal & Child Health

THIS BUDGET MAY BE REVISED WITH THE WRITTEN APPROVAL OF THE DIRECTOR OF MATERNAL & CHILD HEALTH

INSTRUCTIONS – PROGRAM BUDGET REPORTING AND INVOICING FORM INS

Name:

Name and address of the provider preparing the report. This name should be the same party as indicated in the contract with MCH.

Contract Name and Contract Number:

Identify the program for which the budget is being prepared and the City contract number. Obtain the City contract number from page 1 of the contract.

For the period of:

These dates represent the cumulative period for which the report is prepared, for example, where the contract begins on 7/1 the voucher submitted on 8/31 is for the period of 7/1 to 8/31.

Total MCH Funds Approved:

Indicate the amount of MCH funding approved as stipulated in the contract or the amount being requested if this is a budget being submitted for funding.

Certification Statement:

Prepared by/Telephone Number:

Indicate the name and phone number of the individual at the corporation who has prepared the budget report/invoice.

Administrator or Executive Director:

The individual who is contractually responsible to MCH must sign and date the budget report/invoice.

Program Budget Request Form

Section I – Cumulative Revenue and Income Earned Applicable to Eligible Expenses:

Indicate in this part all revenue and income of the program to be applied to the total eligible expenses shown on page 2, Section III, Contract Expenses for either the proposed budget.

Cumulative Non-MCH Revenue and Income:

In this section, the facility must report the cumulative amount of revenue and income earned from all sources of funding other than contractual payments from MCH. For more specific instructions as to the manner of reporting such revenue and income, please observe the following:

Revenue – Revenue is classified as funding which has been obligated to the service provider by a grant, contract, award letter or other documented agreement. Revenues are earned as a consequence of a formal funding commitment accomplished in advance of the work or services to be performed. Revenue commitments should include as an integral part identification as to purpose for which the funds are obligated.

Direct Federal – Revenue earned by the service provider directly from the Federal government for provision of services included in this program. The intent is to identify Federal dollars earned by the recipient to defray existing costs or expand service scope or capacity.

Revenue from other city Agencies – Revenue earned for client service costs wherein the source of payment is a City agency other than MCH.

Other Revenue – Revenue earned from other government or private entities.

Income – Income is classified a funding which earned by the service provider as a consequence of operating. Income funds are not accompanied by a long-term promissory feature (formal funding commitment) on the part of the payer. In the most common instance, income is derived from 3rd party payers as a reimbursement for services rendered to insured, eligible, or self paying populations. Interest and donations (funding obtained without obligation on the part of the donor) would also be classified as income.

Client Fees – Income earned directly from liable clients in full or partial payment for services received.

Private Health Insurance – Income earned from insurance carriers, e.g., Blue Cross/Blue Shield, employer and/or union health plans and private purchase health insurance.

Medical Assistance – Income earned from the Pennsylvania Department of Public Welfare for reimbursable medical Services.

Other Third Party Fees – Income earned in the form of unspecified sources, such as interest, donations i.e., funds donated to the service provider as a general contribution wherein the donation recipient determines the purpose for which the funds will be spent) from sources such as private firms, union, charitable organization and individuals. Interest credited or accrued during the fiscal year should also be included.

In-Kind Contributions – Use this to indicate funding which comes from the service provider itself.

Section II – Request for MCH Revenue for Program Budget

This section is to be used by the provider (1) when submitting the original budget and 2) when requesting a budget revision.

Total Program Cost: Indicate the total eligible expenses incurred under this contract. This amount is obtained from the total of Section III, Column 2.

Less: Non-MCH Revenues and Income: Deduct the amount of revenue and income as calculated on the total line of Section I.

Request for Funding to MCH: This item is calculated by subtracting Non-MCH Revenues and Income from Total Program Cost and represents the actual amount of the contract.

THIS BUDGET MAY BE REVISED WITH THE WRITTEN APPROVAL OF THE DIRECTOR OF MATERNAL & CHILD HEALTH

MATERNAL AND CHILD HEALTH
 500 SOUTH BROAD STREET
 PHILADELPHIA, PA 19146

SECTION III – CONTRACT EXPENSES	CURRENT CONTRACT BUDGET FY 96 (COLUMN 1)	CONTRACT BUDGET FY 97 (COLUMN 2)	OTHER PROGRAM FUNDS FY 97 (COLUMN 3)	TOTAL PROGRAM FUNDS (SUM OF COLUMNS 2, 3 & 4)
BUDGET CATEGORIES				
PERSONNEL SERVICES (100)				
21-CLIENT ORIENTED SERVICE SALARIES	55,600	58,749		
22-CLIENT ORIENTED SERVICE BENEFITS				
23-STAFF DEVELOPMENT				
SUB-TOTAL PERSONNEL SERVICES	11,676	11,456		
	67,276	70,205		
OPERATING EXPENSES (300)				
301-BOARD EXPENSES				
302-CONSULTANT EXP				
311-RENTS	4,271	4,718		
312-UTILITIES				
313-INSURANCE	2,224	2,636		
314-HOUSEKEEPING				
321-COMMUNICATION	1,131	691		
331-OFFICE SUPPLIES	1,000	517		
341-MEDICAL SUPPLIES				
342-DRUGS				
343-FOOD AND CLOTHING				
344-REHABILITATION SUPPLIES	3,000	1,000		
351-STAFF TRAVEL	960	1,452		
352-CLIENT TRANSPORT				
361-PURCHASED PHYSICIAN SERVICES				
362-PURCHASED CLIENT ORIENTED SERVICES				
362-PURCHASED CLIENT ORIENTED SERVICES				
383-OTHER OPERATING EXPENSES	10,138	8,781		
SUB-TOTAL OPERATING EXPENSES	22,724	19,795		
FIXED ASSETS (400)				
401-CLIENT EQUIPMENT AND FURNISHING				
402-CLIENT SERVICES EQUIPMENT				

SUBTOTAL FIXED ASSETS				
TOTAL		90,000	90,000	

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SECTION III – CONTRACT EXPENSES BUDGET CATEGORIES	TOTAL CONTRACT BUDGET FY 97	FIRST QUARTER BUDGET	SECOND QUARTER BUDGET	
PERSONNEL SERVICES				
111-ADMINISTRATIVE SALARIES 121-CLIENT ORIENTED SERVICE SALARIES 122-CLIENT ORIENTED SERVICE BENEFITS 123-STAFF DEVELOPMENT				
	58,749	14,687	14,687	
	11,456	2,864	2,864	
SUBTOTAL: PERSONNEL SERVICES	70,205	17,551	17,551	
OPERATING EXPENSES (300)				
301-BOARD EXPENSES				
302-CONSULTANT EXPENSES				
311-RENTS	4,718	1,180	1,180	
312-UTILITIES				
313-INSURANCE	2,636	659	659	
321-COMMUNICATION	691	173	173	
331-OFFICE SUPPLIES	517	129	129	
341-MEDICAL SUPPLIES				
344-REHABILITATION SUPPLIES	1,000	250	250	
351-STAFF TRAVEL	1,452	363	363	
352-CLIENT TRANSPORT				
383-OTHER OPERATING EXPENSES	8,781	2,195	2,195	
SUBTOTAL OPERATING EXPENSES	19,975	4,949	4,949	
FIXED ASSETS (400)				
401-OFFICE EQUIPMENT & FURNISHINGS				
402-CLIENT SERVICES EQUIPMENT				
410-CAPITAL LEASES				
SUBTOTAL FIXED ASSETS				
TOTAL	90,000	22,500	22,500	

INSTRUCTIONS – PERSONNEL ROSTER

AGENCY CORPORATE NAME:

ENTER AGENCY'S CORPORATE NAME AS IT APPEARS ON THE CORRESPONDING CONTRACT.

CONTRACT NUMBER AND CONTRACT NAME:

ENTER THE CORRESPONDING CONTRACT NUMBER AND CONTRACT NAME.

CUMULATIVE REPORTING PERIOD:

ENTER THE CUMULATIVE REPORTING PERIOD WHICH AGREES WITH THE COM
THE CORRESPONDING CONTRACT.

HOURS PER WEEK:

ENTER THE TOTAL HOURS PER WEEK THAT THE EMPLOYEE IS EMPLOYED BY THE AGENCY.

ANNUAL RATE:

ENTER THE APPROVED ANNUAL SALARY THE EMPLOYEE RECEIVES FROM THE AGENCY REGARD
BE CHARGED TO MATERNAL AND INFANT HEALTH.

CUMULATIVE AMOUNT PAID:

ENTER THE TOTAL AMOUNT THE EMPLOYEE HAS BEEN PAID BILLABLE TO MATERNAL AND INFA
COMMENCEMENT OF THE CONTRACT. (FOR BUDGET PREPARATION PURPOSES, THIS IS THE TOT
BILLED DURING THE CONTRACT PERIOD).

SALARY BREAKDOWN BY ACTIVITY BY DOLLARS OF % OF TIME:

IF AN EMPLOYEE'S SALARY IS BEING CHARGED TO MORE THAN ONE FUNDED ACTIVITY, INDICA
AMOUNT BEING CHARGED TO MATERNAL AND INFANT HEALTH FOR EACH ACTIVITY. DISTINGUI

EMPLOYEE TERMINATION DATE:

IF AN EMPLOYEE CHARGED TO THE CONTRACT TERMINATES EMPLOYMENT DURING THE CONTR
TERMINATION DATE IS TO BE REFLECTED. THE EMPLOYEE AND ALL INFORMATION PREVIOUSLY
CONTINUE TO BE REFLECTED ON SUBSEQUENT REPORTS WITH THE TERMINATION DATE. IF A R
TERMINATED EMPLOYEE IS HIRED, THE REPLACEMENT EMPLOYEE SHOULD BE LISTED ON THE P
THE TERMINATED EMPLOYEE.

